STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

maintenance, or insufficient nursing staff will not be considered staffed beds. It shall be the responsibility of the provider to determine, at least monthly, its number of staffed beds. A schedule is subject to audit. If no schedule of staffed beds is received, staffed beds will be the number of beds at the end of the cost report period. For psychiatric providers, the minimum occupancy adjustment will apply to services on and after July 1, 1988. The minimum occupancy adjustment will be applied before the adjustment specified in B(4). Effective October 1, 1989, Tennessee Medicaid will not impose a minimum occupancy penalty.

E. Rate or Payment Adjustment

(1) Prospective per diem rates or lump sum payment amounts are subject to adjustment in the event of a mistake.

(2) Operating per diem rates may be adjusted if there is a significant change in case mix resulting in a $25,000 effect on Tennessee Medicaid reimbursement. Case mix, for this purpose, is a diagnostic or therapeutic related factor requiring either an increase or decrease in the professional staff per patient ratio. Requests for adjustments must be accompanied by detailed supporting information. Such rate adjustments if approved become effective on the first day of the month following the approval.

(3) Providers may request an increase in monthly interim payments for return on equity, capital, and direct medical education if a provider's actual amounts are expected to exceed the estimated amount by at least 25%. Supporting financial data must be submitted with the request. No more than one request per year for an increase will be accepted per provider. The Commissioner reserves the right, after notifying the provider, to decrease estimated payments when information is made available indicating the estimated payments are materially higher than what is actually being incurred.

F. Medicaid Disproportionate Share Adjustment (MDSA) effective July 1, 1988. Inpatient psychiatric hospitals having a utilization

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MAR 3 1 1989

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

ratio at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments or a low income utilization rate exceeding 25 percent will receive a 1% adjustment to the prospective rate for each percentage above one standard deviation above the mean Medicaid utilization rate up to a cap of 3%; or a 2% adjustment to the prospective rate for each percentage above the 25% low income utilization rate up to a cap of 3%.

(1) Low income utilization rate will be calculated as follows and will use information obtained from the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

(a) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

(b) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

(2) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

(3) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(4) Beginning July 1, 1988, the disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July-June. This will be estimated based on projections from historical experience and the addition of any expected improvements.

(5) Effective July 1, 1989, psychiatric hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a utilization ratio of 14% or one standard deviation above the mean utilization ratio for all hospitals, whichever is lower, will be provided a payment incentive. The MDSA shall not be subject to trending. The MDSA will be the higher of (a) or (b) but shall not exceed 34%.

(a) The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14% or one standard deviation above the mean, whichever is lower.

(b) The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient reported Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but are less than 4,000.

(c) No total payment of the disproportionate share adjustment will exceed 80% of inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

(6) Psychiatric hospitals that do not qualify under the criteria in (5) but have a low-income inpatient utilization rate exceeding 25% will receive the following payment incentive:

(a) The prospective rate will be adjusted upward by 2% for each percentage above 25% up to a cap of 10%.

(b) No total payment of the disproportionate share adjustment will exceed 80% of inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

(c) Low-income utilization rate will be calculated as follows from information obtained from the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that is, reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(7) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(8) The disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July - June. This will be estimated based on projections from historical experience and the addition of any expected improvements.

(9) Effective October 1, 1992, the Medicaid disproportionate share adjustment will not be determined as defined at F. and subsequent paragraphs (1)-(8), but will be determined as described herein. Psychiatric hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a 9.31% Medicaid utilization ratio or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c) but cannot exceed 10% of the inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purposes of this calculation Medicaid days will not include days reimbursed by the Primary Care Network. For the purposes of this calculation charity, unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both in-state and out-of-state services. For the purposes of computing the MDSA, the MDSA prospective rate will be considered to be the operating per diem for the current year, prior to the application of the current year trend, plus a capital per diem and a direct medical education per diem.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

(a) The prospective rate will be adjusted upward by factor of 5.8 times the difference between the actual utilization rate if it exceeds 9.31% and a 9.31% utilization rate.

(b) The prospective rate will be adjusted upward by 5.8% times the number of days above 1,000 days divided by 1,000 days.

(c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate if it exceeds 25% and a 25% low income utilization rate. This adjustment will be capped at 10%.

(d) Low-income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid assistance under an approved Medicaid State Plan) that is reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

(e) Each year a redetermination of the MDSA will be made. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination.

(f) The disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days. This will be estimated based on projections from historical experience and the addition of any expected improvements. For the period beginning July 1, 1993, the disproportionate share adjustment will be established in June and will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming state fiscal year, July-June. This will be estimated based on projections from historical experience and the addition of any expected improvements.

(g) The total amount of MDSA payments for both acute care and psychiatric hospitals will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments based on item (7)(g) of the state plan for reimbursement for inpatient hospital services, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment.

(10) Effective July 1, 1993, psychiatric hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a 10.45% Medicaid utilization ratio or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c) but cannot exceed 10% of inpatient and outpatient charity

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purpose of this calculation Medicaid days will not include days reimbursed by the Primary Care Network. For the purpose of this calculation charity, unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both in-state and out-of-state services.

(a) The prospective rate will be adjusted upward by a factor of 5.8 times the difference between the actual utilization rate and a 10.45% utilization rate.

(b) The prospective rate will be adjusted upward by 5.8% times the number of days above 1,000 days divided by 1,000 days.

(c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.

(d) Low-income utilization rate will be calculated as follows from information obtained from the 1991 Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT DEC 22 1993

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that are reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(e) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(f) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the number of Medicaid days reported on the 1992 cost report. In cases where the 1992 report is unavailable, the latest report on file will be used.

(g) The total amount of MDSA payments for both acute care and psychiatric hospitals will be limited by a federal cap. When allocating the amount of payments that will be made the amount of payments based on item 8(g) of the State plan for reimbursement for inpatient hospital services will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment.

The calculation would be made in this manner: Tennessee Medicaid will total the amount of MDSA to be provided to all hospitals, both acute and psychiatric, prior to the test for the federal cap. If this total exceeds the federal cap, we will subtract from the federal cap amount, the amount calculated as a result of item (7)(g) of the state plan for reimbursement for inpatient acute care hospitals (referenced above). We will take the remaining

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT DEC 22 1993

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

amount and divide it by the total potential MDSA for the industry less item (7)(g) to obtain a percentage by which each hospital's MDSA payments outside of item (7)(g) will be reduced.

G. New Providers - New providers who have not submitted a cost report and who are entering the program for the first time will be required to submit a budgeted cost report from which an interim prospective operating rate will be set. Each new provider must submit an actual cost report covering the first full year of actual operations, at which point a final prospective operating rate, with a retroactive adjustment, will be set. A change of ownership does not constitute a new provider. The budgeted cost report will also be used to estimate interim payments for capital and direct medical education.

H. Lower of Cost or Charges Limit - In the base year, the lower of cost or charges limitation will be waived for prospective rate determination purposes only. The limitation will, however, be applied for settlement purposes for all periods prior to a facility's first fiscal year under prospective payment. Carry forwards of unreimbursed costs will not be recognized once a provider's initial fiscal year under the prospective payment method has begun.

2. Method for Paying Providers Which Are Exempt from Prospective Payment Methodology - The per diem reimbursable costs for the Medicaid providers of inpatient hospital services exempted from the prospective methodology will be determined in accordance with Medicare principles of cost reimbursement in effect on October 1, 1982, and described in 42 CFR

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